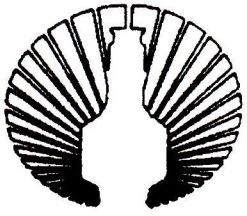

"Your Image Is Our Focus"-
Medical Imaging Consultants

REQUEST FOR RELEASE OF MEDICAL RECORDS

TO: _____
(Physician's Name or Hospital)

_____
(Address)

_____
(City) (State) (Zip)

In accordance with the Food and Drug Administration, a patient may request their mammograms be maintained at a facility other than the originator. **The patient requested we keep your mammograms at our facility**. This is to notify you that we are honoring their request.

My full name is: _____
(Please Print)

My birth date is: _____

Previous mammograms were done: _____
(Date)

Please send these mammograms to: MEDICAL IMAGING CONSULTANTS, P.C.
7950 HARRISON STREET
OMAHA, NEBRASKA 68128

Thank you for your prompt mailing of my films.

Sincerely,

_____

Medical Imaging Consultants, 7950 Harrison Street, Omaha, NE 68128
(402) 592-0711

Please Print

PATIENT INFORMATION

LAST NAME _____ FIRST NAME_____ SEX ____DOB_____AGE_____

PREVIOUS NAME IF APPLICABLE_____SOCIAL SECURITY NUMBER _____

ADDRESS _____ PHONE (HOME) _____

CITY, STATE _____ (CELL) _____

ZIP CODE _____ (WORK) _____

EMPLOYER _____ OCCUPATION_____

ADDRESS _____ CITY, STATE, ZIP CODE _____

IN CASE OF EMERGENCY CONTACT: _____ PHONE# _____

REFERRED BY NAME_____ _____ PHONE _____

E-Mail Address_____

PARENT, GUARDIAN or SPOUSE

LAST NAME _____ FIRST NAME_____SEX ____ DOB_____AGE_____

ADDRESS _____ SOCIAL SECURITY NUMBER _____

CITY, STATE _____ PHONE (HOME) _____

ZIP CODE _____ (WORK)_____

OCCUPATION _____ EMPLOYER _____

ADDRESS _____ CITY, STATE, ZIP CODE _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY _____

NAME OF INSURED _____DATE OF BIRTH _____SOCIAL SECURITY # _____

SECONDARY INSURANCE COMPANY _____

NAME OF INSURED _____DATE OF BIRTH _____SOCIAL SECURITY # _____

I understand as the Consenting Party, I am responsible for payment of this account

PURPOSE OF YOUR VISIT _____

IS **PREAUTHORIZATION OR PRECERTIFICATION** NEEDED FOR THIS VISIT? YES _____ NO _____

IF **YES** WAS YOUR INSURANCE COMPANY CALLED? YES _____ NO _____

If this visit is due to an accident or injury please ask the receptionist for an Accident/Injury form.

Release and Assignment

This patient registration form must be completed in its entirety & the Release & Assignment Authorization signed by the Responsible / Consenting Party prior to treatment. Medical Imaging Consultants considers this information a condition of treatment.

1. I hereby authorize the Providers of Medical Imaging Consultants to perform such procedures as may be deemed necessary in the diagnosis & treatment of the patient.
2. I hereby authorize release of any medical information regarding this visit to my insurance and/or primary care physician & also assign to the provider all payments from Medicare, Midlands Choice, Blue Cross/Blue Shield, Mutual of Omaha & Medicaid.
3. I understand that I am financially responsible for all charges whether or not paid by insurance.
4. I understand that not all providers at Medical Imaging Consultants may be a participating provider with my insurance. I understand that I am responsible for charges not covered by my insurance.
5. I understand and agree to the above conditions.

AUTHORIZATION SIGNATURE _____ **DATE** _____

This agreement will remain on file for approximately one year & will be considered a condition of all treatments until a new form is completed.

Form 802

Medical Imaging Consultants, P.C.
7950 Harrison Street
Omaha, NE 68128
(402) 592-0711

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Today's Date: _____
Patient's Name: _____
Birth Date: _____
Authorization #: _____

ACKNOWLEDGMENT OF RECEIPT

OF

PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

The undersigned does hereby acknowledge receipt of Medical Imaging Consultants' Notice of Privacy Practices for Protected Health Information.

_____
Patient Signature Date

_____
Patient Signature Date

_____
Patient Signature Date

_____
Patient Signature Date

_____
Patient Signature Date